

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for an autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
AERY, George Aery		Sept 9, 1981				12:15 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.	
Male	White	2 29 08		73		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.Y.	U.S.A.			CARROLL MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster	CARROLL Co. Hospital			Accountant			Public Utilities		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Md.	Carroll	Sykesville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7200 Third Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Herman Aery		Loretta Cornell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		086038755		Audrey Aery - Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ASPIRATION</u> (c) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 9, 1981</u> , to <u>Sept 9, 1981</u> , that (I) (we) last saw the deceased alive on <u>Sept 9, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE						22c. DATE SIGNED	
Arthur L. Rudolph MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						9/9/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
ARTHUR L. RUDOLPH MD		524-B BALTIMORE BLVD WESTMINSTER MD 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		9-10-81		Security Process		Baltimore or Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS							
Harry W. Haight		Sykesville, Md.							
		SEP 14 1981							

BP

ACK, George

LD

M

ASPIRATION  
PNEUMONIA  
CVA

Arthur & Linda

ARTHUR L. GORDON JR. 354-B BALTIMORE BLVD

2/17/81  
WESTMINSTER  
MD 21157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Ivy Elizabeth Ashburn					2a. DATE OF DEATH MONTH DAY YEAR 9/18/81			2b. HOUR 1:35pm		
1. SEX Female		4. RACE White		3. DATE OF BIRTH MONTH DAY YEAR 2 14 08		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. UNDER 1 YEAR MONTHS DATE 7 4		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2223 Dulany Terrace				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert M. Harding					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Schilling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-10-9380		17. INFORMANT ADDRESS Stanley W. Ashburn, Sr., Same As #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OVARIAN CARCINOMA</u> 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WITHIN <input type="checkbox"/> NOT WITHIN <input type="checkbox"/> AT WORK <input type="checkbox"/> ACCIDENT <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>2/4/81</u> to <u>9/18</u> 19 <u>81</u> , that (2) we last saw the deceased alive on <u>8/10/81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Diana H. Griffiths</u>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/18/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Diana H. Griffiths, M.D.					22e. ADDRESS 900 Caton Avenue					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-22-1981		23c. NAME OF CEMETERY OR CREMATORY Lorraine			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.					25a. DATE SEP 22 1981					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 3 8 3 1

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anita Bankard Bair		2a. DATE OF DEATH MONTH DAY YEAR 9-25-81 2148 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 12 1909	
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	9b. CITIZEN OF WHAT COUNTRY? U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Bankard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Sheets	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 218-46-0770	
17. INFORMANT ADDRESS Scott S. Bair Sr. Westminster Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-4-1979, to 9-25-1981, that (I) (we) lost saw the deceased alive on 9-24-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Chitrachudun Nagananna MD		22c. DATE SIGNED 9/25/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHUDUN NAGANNA		22e. ADDRESS 174 E Main St. Westminster MD 21157	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-1981	
23c. NAME OF CEMETERY OR CREMATORY Westminster		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24. FUNERAL DIRECTOR NAME Pritts Funeral Home		25a. DATE REC'D. BY REGISTRAR OCT 5 1981	
ADDRESS Westminster, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 3 8 3 2

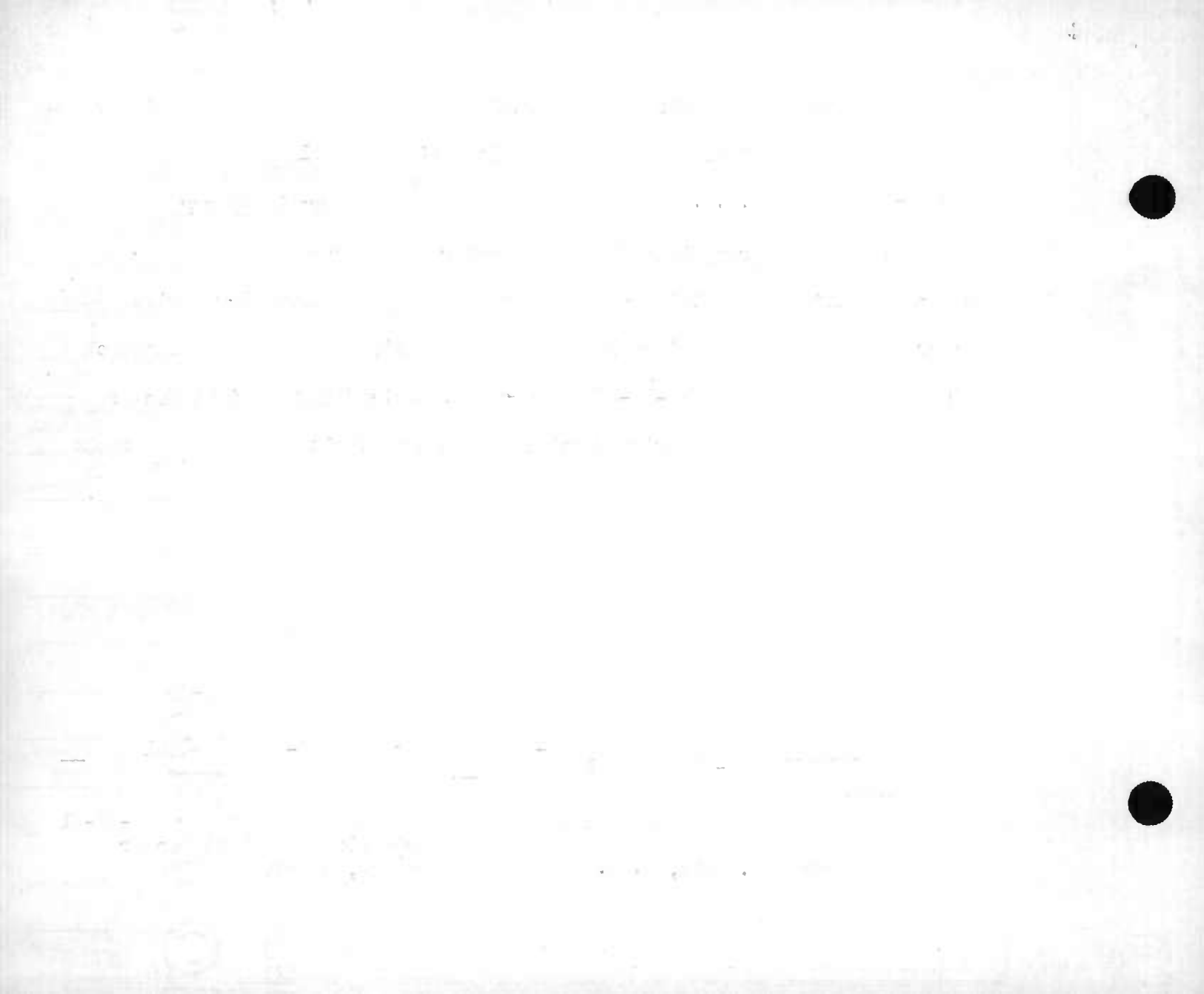
1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Betty Mable Beierfeld</b>			2a DATE OF DEATH MONTH <b>09</b> DAY <b>08</b> YEAR <b>81</b>			2b HOUR <b>9</b> <b>4</b> M					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>08</b> DAY <b>15</b> YEAR <b>20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		7 IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		8 IF UNDER 24 HRS HOURS <b>00</b> MIN. <b>00</b>	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.					
12 CITY OR TOWN OF DEATH <b>Sykesville</b>		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Springfield Hospital Center</b>				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		15 KIND OF BUSINESS OR INDUSTRY <b>none</b>			
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Carroll</b> 13c CITY OR TOWN <b>Baltimore</b>				14 INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15 STREET ADDRESS <b>3618 COTTAGE AVE.</b> <b>19 Warren Park Drive</b> 21215					
16 FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>Beierfeld</b> LAST <b>Goldie</b>				17 MOTHER'S MAIDEN NAME FIRST <b>Goldie</b> MIDDLE <b>Weinstock</b> LAST <b>Weinstock</b>							
18a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		18b SOCIAL SECURITY NO. <b>219-16-8780</b>		19 INFORMANT <b>ISADORE STEIN</b> ADDRESS <b>3612 GLENGYLE AVE.</b>		20 <b>Records, Springfield Hospital Center</b>		21 <b>21215</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ovarian carcinoma with metastasis</b> 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>11-18</b> 19 <b>43</b> , to <b>09-08</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>09-08</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Octavio A. Ruiz</b> DEGREE <b>M.D.</b>						22c DATE SIGNED <b>09-08-81</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Octavio A. Ruiz, M. D.</b>			
22e ADDRESS <b>Springfield Hospital Center</b> <b>Sykesville, Maryland 21784</b>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>9/9/81</b>		23c NAME OF CEMETERY OR CREMATORY <b>OHEL YAKOV</b>		23d LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE				
24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD</b> 21215						25a DATE REC'D. BY REGISTRAR <b>SEP 10 1981</b>		25b REGISTRAR'S SIGNATURE <b>James J. Katten</b>			

BP

DHMM-16 20M  
(VRA 15, 4) 7/78





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Emily W BORTNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-6-81</b>			2b. HOUR <b>PM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 7 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL CO GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>General</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Plant</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2636 Old Westminster Pike</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles A Wenig</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Christina Horpel</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NOTE</b>		17. INFORMANT ADDRESS <b>Charles Frank Sykesville MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>unknown</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> , 19 <b>81</b> , to <b>7/6</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Norman A. Poulsen</b> M.D.						22c. DATE SIGNED <b>9/6/81</b>		22d. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NORMAN POULSEN</b>						22f. ADDRESS <b>218 WASHINGTON HGT. MED. CENTER WESTMINSTER, MD. 21157</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-9-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott Howard MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert &amp; Ruth L. Westminster, Md</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 14 1981 Frances Jean Tharion</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Rita Frances Bradford</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 30 81</i>			2b. HOUR <i>3:10 P.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 06 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i>				
10. CITY OR TOWN OF DEATH <i>Mt. Airy</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pleasant View Nsg. Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Finksburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2407 Shawnee Drive</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John O'Connor</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Fulton</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS <i>Mrs. Joan Malinowski same</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory arrest</i> <i>5965</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>gran negative zepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>urinary bladder paralysis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>see</i> <i>1 hr.</i> <i>&gt; 542s</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Severe Parkinsons disease, COPD, CBS, &amp; scur</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>4/79</i>				
22a. I certify that (I, this hospital) attended the deceased from <i>9/30/81</i> to <i>9/30/81</i> , 19 <i>81</i> , that (we) last saw the deceased alive on <i>9/30/81</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Melvin J. Gordon</i>						22c. DATE SIGNED <i>9/30/81</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Melvin J. Gordon</i>		
22e. ADDRESS <i>2000 Century Plaza Columbia Md</i>						22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/>		22g. REGISTRAR'S SIGNATURE <i>Thomas J. Malinowski</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Oct. 5, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Most Holy Redeemer</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>						25a. DATE REC'D. BY REGISTRAR <i>OCT 2 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. Malinowski</i>		

MEDICAL CERTIFICATION

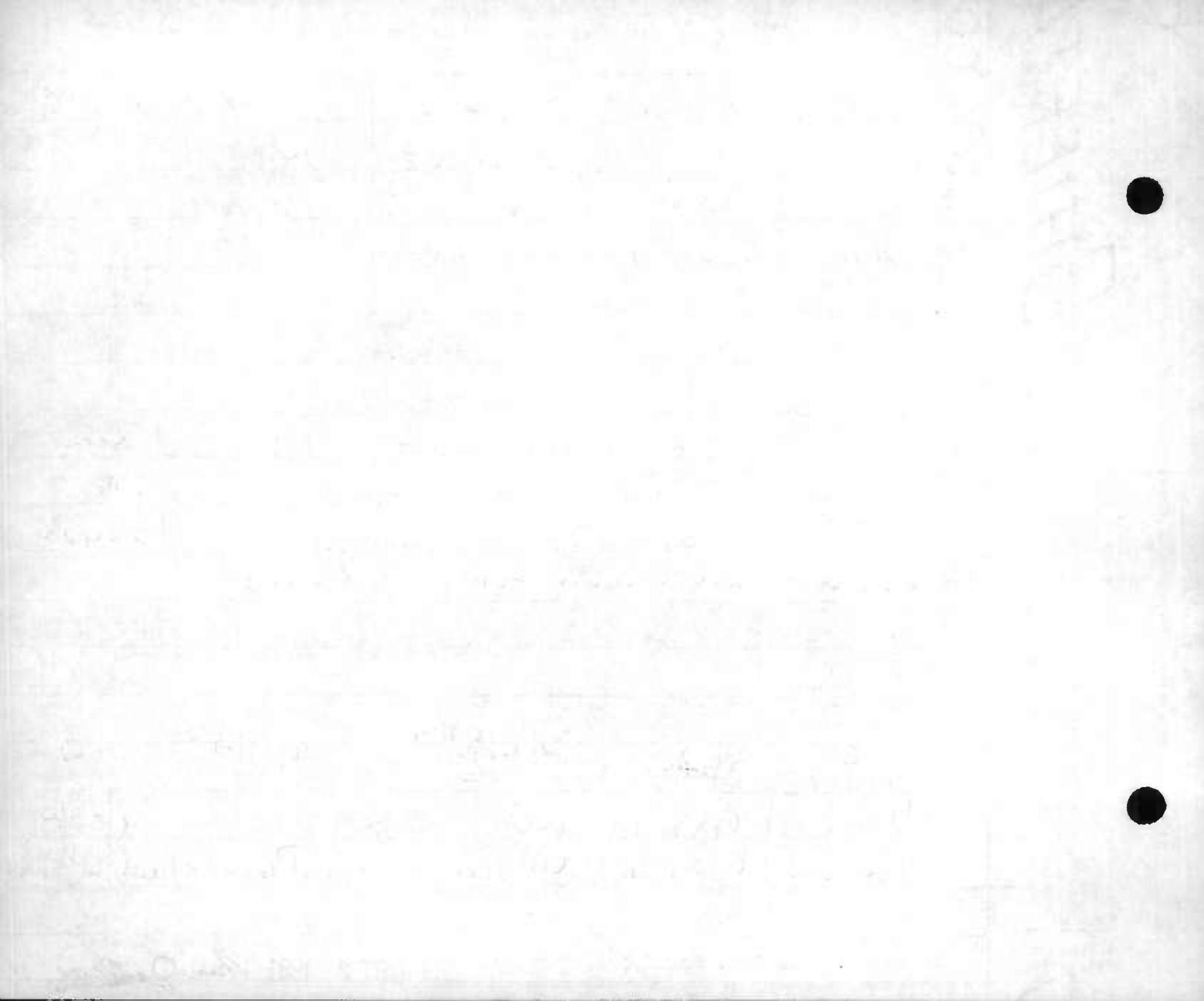
3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Howard Vernon Bragg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-1-81</b>		2b. HOUR <b>1810 P</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5/27/11</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b>	7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.		
10 CITY OR TOWN OF DEATH <b>Westminister</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Manager</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Westminister</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Vernon Bragg</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Madeline Finn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-01-2926</b>	17 INFORMANT ADDRESS <b>5 Andree Place William M. Bragg Mercerville, N.J. 08619</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1629 carcinoma of the lung</b> IMMEDIATE CAUSE (a) <b>carcinoma of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/30</b> 19 <b>81</b> , to <b>9/1</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>9/1</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Suburban Medical Center</b>				22c. DATE SIGNED <b>9/1/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/4/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>
24 FUNERAL DIRECTOR NAME <b>Witzke P.</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 3 1981</b>		
1630 Edmondson Avenue, Catonsville, Md. 21228			25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>		

MEDICAL CERTIFICATION

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23836	
1. DECEASED NAME (TYPE OR PRINT) <b>Oscar (NMN) Brooker's</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>9 30 81</b>		2b. HOUR <b>845</b>		2c. DATE OF DEATH PROMOUNCED DEAD <b>9 30 81</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 18, 1916</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>64 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>1 12</b>	IF UNDER 24 HRS. HOURS MIN. <b></b>	7c. DATE OF DEATH PROMOUNCED DEAD <b>9 30 81</b>		7d. HOUR <b>845</b>		7e. DATE OF DEATH PROMOUNCED DEAD <b>9 30 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.,</b>					
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Group Leader-Congoleum Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Finksburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Brothers</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Emily Barnes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-12-8766</b>		17. INFORMANT ADDRESS <b>Virginia R. Brothers, Same As #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Richard A. Jones</i>		EXAMINER'S NAME (TYPE OR PRINT) <b>Richard A. Jones</b>		TITLE (SPECIFY) <b>MD.</b>		MEDICAL EXAMINER <b>CE George Westminister Md.</b>		DATE SIGNED <b>10/01/81</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-3-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gamber, Carroll, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr.,</b>						ADDRESS <b>Sykesville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 5 1981</b>		25b. REGISTRAR <i>[Signature]</i>	



100% Cotton Fiber

100% Cotton Fiber

100% Cotton Fiber

100% Cotton Fiber

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CAROLYN BOYD CARTER</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>9</b> DAY <b>1</b> YEAR <b>1981</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>JUNE</b> DAY <b>23</b> YEAR <b>1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>1</b> YEAR <b>1981</b> 2d. HOUR <b>6:18</b> AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Westminster</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hsp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>CARROLL</b>		13c. CITY OR TOWN <b>MANCHESTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3504 Water Tank Road</b>	
14. FATHER'S NAME FIRST <b>MILTON</b> MIDDLE <b>R</b> LAST <b>BOYD</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ADA</b> MIDDLE <b>?</b> LAST <b>MCLAREN</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-38-4735</b>	
17. INFORMANT <b>James D. Carter</b>				17. ADDRESS <b>3504 Water Tank Rd. Manchester, Md.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Cirrhosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>5712</b>				DUE TO, OR AS A CONSEQUENCE OF (b)				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>chronic alcoholism</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H. R. Guard</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>9/1/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Pann Street, Balto. MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>				23d. LOCATION CITY OR TOWN <b>Hydesville</b> COUNTY <b>Carroll</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>H. J. Eckhardt</b> ADDRESS <b>Manchester, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1981</b>				25b. REGISTRAR'S SIGNATURE <b>James D. Carter</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 3 3 3 8

1. FOR  
STATE  
REGISTRAR

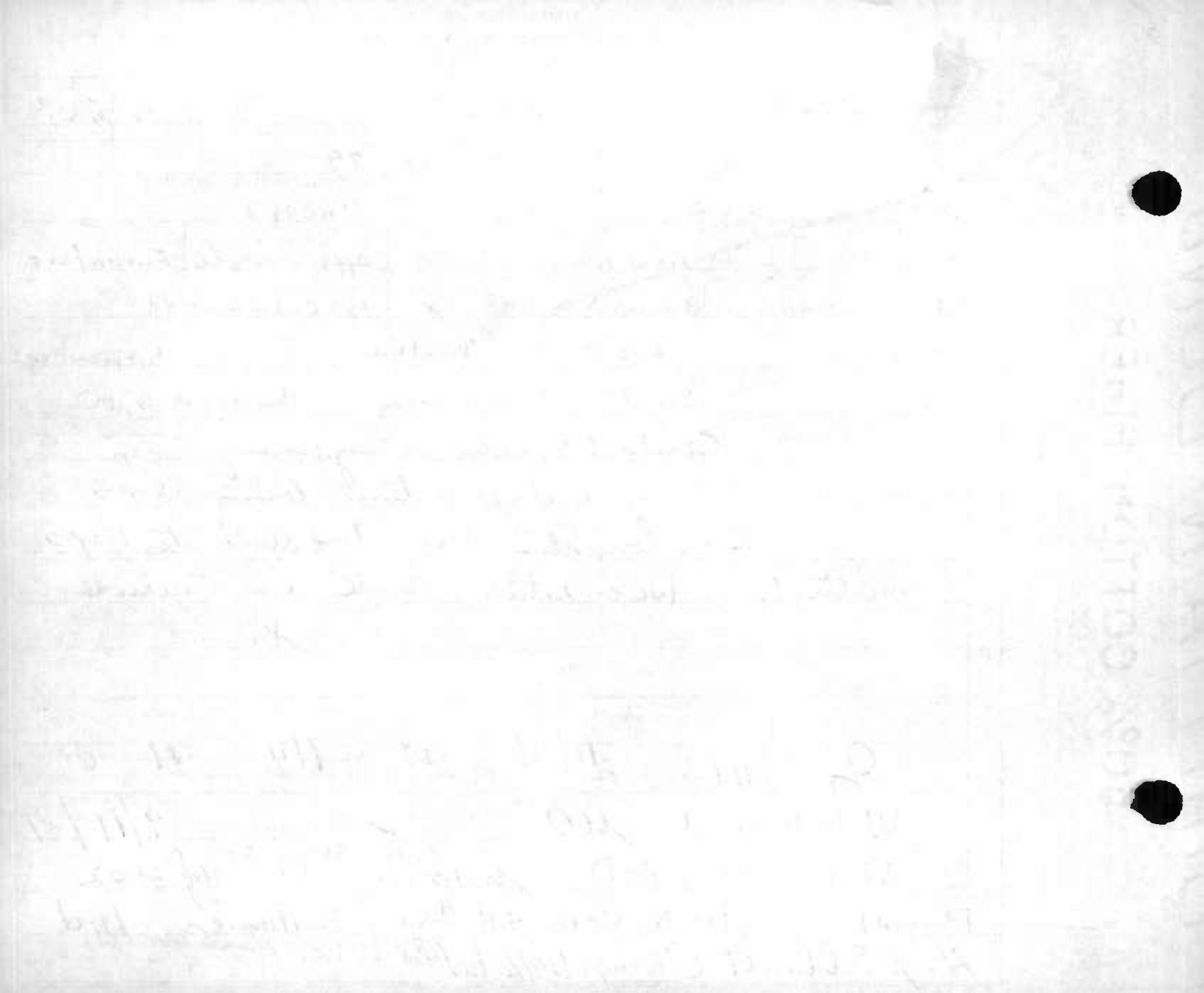
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Louise</u> MIDDLE <u>Carey</u> LAST <u>Carey</u>			2a. DATE OF DEATH MONTH <u>9</u> DAY <u>11</u> YEAR <u>81</u> 2b. HOUR <u>5:20 P.M.</u>		
3. SEX <u>F</u>		4. RACE <u>Cauc</u>		5. DATE OF BIRTH MONTH <u>10</u> DAY <u>5</u> YEAR <u>1901</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>		8. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Careol</u> MD.		10. CITY OR TOWN OF DEATH <u>Manchester</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Long View Nursing Home</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Office work</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. CITY OR TOWN <u>Bethesda</u> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13d. STREET ADDRESS <u>127 Cedarvale Rd.</u>	
14. FATHER'S NAME FIRST <u>Constance</u> MIDDLE <u>KRAFT</u> LAST <u>Bertha</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Bertha</u> MIDDLE <u>Kaffenberger</u> LAST <u>Kaffenberger</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> 16b. SOCIAL SECURITY NO. <u>216-07-7715</u> 17. INFORMANT <u>James Carey</u> ADDRESS <u>Owings Mills, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Crystalline Rheumatoid Arthritis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 yrs</u> <u>15 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>multiple - Decubitus - acute renal Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>11/12</u> , 19 <u>77</u> , to <u>9/11</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>9/11</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W H Foward MD</u>		DEGREE		22c. DATE SIGNED <u>9/11/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W H Foward MD</u>		22e. ADDRESS <u>3223 Main St</u> <u>March 21102</u>			
23a. BURIAL, CREMATION, REMOVAL (BY) <u>Burial</u>		23b. DATE <u>Sept. 4, 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <u>Baltimore</u> <u>MD.</u>		23e. NAME OF REGISTRAR <u>SEP 15 1981</u>		23f. SIGNATURE	
24. FUNERAL DIRECTOR NAME <u>H. J. Schmitt</u> ADDRESS <u>Owings Mills, MD.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth C. Chase</b>					2a. DATE OF DEATH MONTH <b>September</b> DAY <b>25</b> YEAR <b>1981</b>			2b. HOUR M <b></b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>22</b> YEAR <b>1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Carroll</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b>			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>20 Union Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>20 Union Street</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>					
14. FATHER'S NAME FIRST <b>John W.</b> MIDDLE <b>Chase</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Ada</b> MIDDLE <b>Cross</b> LAST <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Eugene Chase Westminster, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebro-vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>15 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>Feb 20</b> 19 <b>67</b> to <b>Sept 25</b> 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>Sept 22</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Julius Chepko</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/28/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julius Chepko</b>					22e. ADDRESS <b>85 1/2 East Green St. Westminster, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-28-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westeran Chapel</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Pritts Funeral Home</b> ADDRESS <b>Westminster, Md.</b>					DATE REC'D. BY REGISTRAR <b>OCT 5 1981</b>				

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Investigation No. 1

Date

File No.

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Subject

Reference

Organization

Position

Grade

Place of Birth

Place of Birth

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



Investigation No. 1

Date

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8 1 2 3 8 4 0	
1. DECEASED NAME (TYPE OR PRINT) <b>Harold Thomas Coon</b>					2a. DATE OF DEATH MONTH <b>9</b> DAY <b>27</b> YEAR <b>81</b>			2b. HOUR <b>0640</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>March</b> DAY <b>19</b> YEAR <b>1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.					
10. CITY OR TOWN OF DEATH <b>Westministe</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3212 Hooper Road</b>				
13a. STATE <b>Md</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>New Windsor</b>							
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Harry</b> LAST <b>Coon</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>May Marie</b> LAST <b>Hines</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218 07 0834</b>		17. INFORMANT ADDRESS <b>Celeste Coon same as above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR YEARS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b> <b>1 HOUR</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DIABETES MELLITUS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>9/27</b> 19 <b>81</b> , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Vincent Fiocco</b>					DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/27/81</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Vincent Fiocco</b>					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept 30, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Scaggsville, Maryland</b> COUNTY STATE					
24. FUNERAL DIRECTOR <b>Walter J. H. [Signature]</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1981</b>					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

David

Ross

Cozort

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 9 14 81 2b HOUR M

3. SEX  
male

4. RACE  
white

5. DATE OF BIRTH  
MONTH DAY YEAR Sept. 14, 1949

6. AGE (IN YEARS)  
LAST BIRTHDAY 32 YRS.

IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD 9 14 1981 2d HOUR M PM 57M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
West Virginia

7b. CITIZEN OF WHAT COUNTRY?  
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Carroll County MD.

10. CITY OR TOWN OF DEATH  
Westminster

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Carroll County General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Machinist  
12b. KIND OF BUSINESS OR INDUSTRY  
Pump Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland

13b. COUNTY  
Carroll

13c. CITY OR TOWN  
Taneytown

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS  
3830 Old Taneytown Road

14. FATHER'S NAME  
FIRST MIDDLE LAST  
Donald

Cozort

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST  
Marjorie

Bailey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
No

16b. SOCIAL SECURITY NO.  
233-78-1372

17. INFORMANT  
ADDRESS  
3830 Old Taneytown Rd.  
Mrs. Donna E. Cozort Taneytown, MD 21787

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?  
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR 9:00PM 9/14 81

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
mechanical injury while operating lathe

21d. INJURY OCCURRED  
WHILE ☒ NOT WHILE ☐  
AT WORK ☒ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  
Mfg. plant

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE  
Worthington Pump Mfg Plant, Taneytown, Carroll Co, MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL  
SIGNATURE

*J.R. Shaw*

TITLE (SPECIFY)  
M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 9/15/81

EXAMINER'S NAME  
(TYPE OR PRINT)

Hormez R. Guard, M.D.

ADDRESS 111 Penn Street, Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) Burial

23b. DATE  
9/18/81

23c. NAME OF CEMETERY OR CREMATORY  
Mt. View Cemetery

23d. LOCATION  
CITY OR TOWN COUNTY STATE  
Harney, Carroll, Maryland

24. FUNERAL DIRECTOR  
NAME

Skiles Funeral Home

ADDRESS 136 E. Baltimore St.  
Taneytown, MD 21787

25a. DATE REC'D. BY REGISTRAR  
SEP 18 1981

25b. REGISTRAR'S SIGNATURE  
*James J. Kestner*

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 2 3 8 4 2				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM JOSEPH CRABBS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 28 1981</b>				2b. HOUR <b>7 A</b> M
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 18 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>86</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL MD.</b>			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>940 WASHINGTON ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Store</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>940 Washington Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Wilson Crabbs</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Fannie Poutson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-01-0544</b>		17. INFORMANT ADDRESS <b>William K. Crabbs Westminster</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (I) (this hospital) attended the deceased from <b>SEPT 27 1981</b> to <b>SEPT 28 1981</b> , that (I) (we) last saw the deceased alive on <b>SEPT 27 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (all) did not view the body after death.									
21h. SIGNATURE <b>Daniel I. Welliver MD.</b>					DEGREE <b>MD.</b>			22c. DATE SIGNED <b>9-30-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL I. WELLIVER MD.</b>					22e. ADDRESS <b>218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND</b>				
23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Krider's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll Md.</b>			
24. FUNERAL DIRECTOR <b>Est. 7th St</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 5 1981</b>				
25b. REGISTRAR'S SIGNATURE <b>Thane J. [Signature]</b>									

BP

1917  
No. 101  
To the  
Honorable  
Commissioner of  
Patents  
Washington, D. C.  
Dear Sir:  
I have the honor to  
acknowledge the receipt  
of your letter of the  
10th inst. and in reply  
to inform you that the  
same has been forwarded  
to the proper authorities  
for their consideration.  
Very respectfully,  
J. H. ...





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8123843				
1. FOR STATE REGISTRAR					2b. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Mae Dern					MONTH DAY YEAR 09 30 81				
3. SEX F					2b. HOUR 1130 M				
4. RACE W					5. DATE OF BIRTH				
5. DATE OF BIRTH MONTH DAY YEAR 01 13 00					6. AGE (IN YEARS LAST BIRTHDAY) 81				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD					8. IF UNDER 1 YEAR MONTHS DAYS				
7b. CITIZEN OF WHAT COUNTRY? USA					9. IF UNDER 24 HRS. HOURS MIN.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker					12b. KIND OF BUSINESS OR INDUSTRY own Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Carroll 13c. CITY OR TOWN Taneytown					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Harry ALBERT Lowman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Mae Haines				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 213-38-7678				
17. INFORMANT ADDRESS MRS. DOROTHY CASS, 14345 SARATOGA AVE #24, SARATOGA, CAL. 95070					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months				
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, colon 1539					DUE TO, OR AS A CONSEQUENCE OF (b) _____				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE:			
22a. I certify that (1) this hospital attended the deceased from 8-17, 19 81, to 9-30, 19 81, that (2) (we) last saw the deceased alive on 9-30, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did not) view the body after death.									
22b. SIGNATURE Alva S. Baker			DEGREE			22c. DATE SIGNED 9-30-81			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker			22c. ADDRESS 218 Washington Hts Med Ctr Westminster MD 21157			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-3-81			23c. NAME OF CEMETERY OR CREMATORY Keyville Union Cem			
23d. LOCATION CITY OR TOWN COUNTY STATE Keyville Carroll MD			23e. DATE REC'D. BY REGISTRAR 10/2/81			23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR NAME SKILES FUNERAL HOME, 136 E BALTA ST. TANETOWN									



CHIEFLAIN

POSITION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 3 8 4 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Jean Ebaugh</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 28 81</b>			2b. HOUR <b>5 a.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 26</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b>			
10 CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Springfield Hospital Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>machine operator</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b>		13b CITY <b>City</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Baltimore</b>		13d STREET ADDRESS <b>4119 White Avenue</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Herbert S. Ebaugh, Sr.</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Belle Mercer</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b SOCIAL SECURITY NO. <b>220-20-4174</b>		17 INFORMANT ADDRESS <b>Records, Springfield Hospital Center</b>				

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF <b>OF BREAST</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>04-13</b> , 19 <b>50</b> , to <b>09-28</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>9-28</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b SIGNATURE <i>E. Senanayake</i>				DEGREE <b>MD</b>		22c DATE SIGNED <b>9-28-81</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. SENANAYAKE, MD</b>				22e ADDRESS <b>Springfield Hospital Center Sykesville, Maryland 21784</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9-29-81</b>		23c NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Belair Md.</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc-6415 Belair Rd.-21206</b>				25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE <b>SEP 29 1981</b> <i>Charles J. VanNathan</i>			

2734 BP

UNITED STATES  
DEPARTMENT OF JUSTICE

10-2-50

Memorandum

For

TO : Mr. Tolson  
FROM : Mr. E. A. Tamm  
SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

X

10-2-50

10-2-50

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10-2-50

10-2-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 2 3 8 4 5 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Margaret Ellen Eckard					9-21-81 9:30 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. HOUR	
Female		Caucasian		7-29-05		76 YRS.		9:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.				Carroll MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County Hosp.				Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
md.		Carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17 Fairview Ave. <del>4312 First Ave.</del>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
John S Study		Emma Reid							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		216-05-09684		Walter Eckard, 17 Fairview Ave, Taneytown, Md. 21787					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pneumonia									
DUE TO, OR AS A CONSEQUENCE OF (b) The same									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1981, to September 21, 1981, that (I) (we) lost saw the deceased alive on September 21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Jose L. Chapulle								9/22/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Jose L. Chapulle		6342 Barnett Ave. Sykesville, Md. 21784							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Sept 24, 1981		Grace Church Cemetery		Taneytown, Carroll, Md.			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DECEASED BY REGISTERED REGISTRAR SIGNATURE			
Skiles Funeral Home		136 E. Balto. St.		Taneytown		Charles J. Smith			

1012

100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

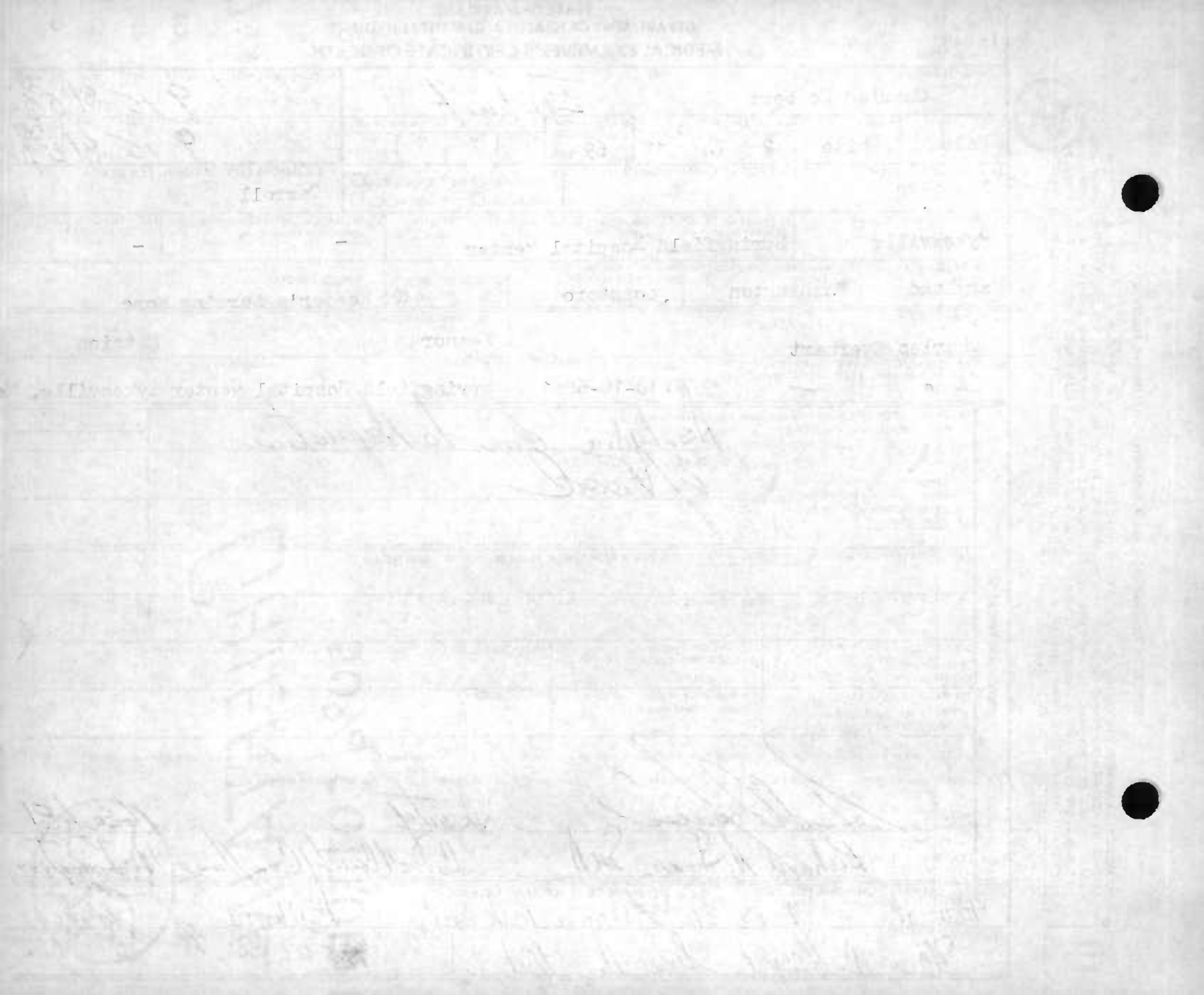
BP  
DHMH - 17  
(VR AT 5 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Herbert</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>9 15 1981</b>		2b. MONTH <b>5</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>24</b> YEAR <b>12</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>69</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Springfield Hospital Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Everhart</b> LAST <b>Everhart</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Leanora</b> MIDDLE <b>Nitsich</b> LAST <b>Nitsich</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>218-10-6861</b>		17. INFORMANT ADDRESS <b>Springfield Hospital Center Sykesville, Md</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF <b>g/food</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>-</b> DUE TO, OR AS A CONSEQUENCE OF <b>-</b> (c) <b>-</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9X0</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Richard A. Jones</b>		TITLE/SPECIFY <b>Surgeon</b>		DATE SIGNED <b>16 Sept 81</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Richard A. Jones</b>		ADDRESS <b>Carroll County/Gen Hosp Westminister</b>		
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>9-18-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Park Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Carroll Md</b>	
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykesville, Md</b>		25a. DATE REC'D BY REGISTRAR <b>SEP 22 1981</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8123847										
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN E. FLANNERY</b>					2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>9 1 81 9 M</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 23 25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56 YRS.</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County MD.</b>				
10. CITY OR TOWN OF DEATH <b>SYKESVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>202 LINCOLN LANE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Morral Children Store</b>		
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Wimpsett</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>May Rogers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-10-3880</b>		17. INFORMANT ADDRESS <b>Patrick Wm. Flannery 5526 Channing Road 21229</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Right Breast, metastatic</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1749</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> 19 <b>80</b> to <b>9/11</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>8/28</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>G. E. Elias</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE E. ELIAS, M.D.</b>				22e. ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/5/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		23e. DATE REC'D. BY REGISTRAR		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR				
						25b. REGISTRAR'S SIGNATURE <b>James Van Natten</b>				

BP



13-11-1945

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>EVELYN May FRANKLIN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 10, 1981</b>			2b. HOUR <b>1245<sup>P</sup></b>	
3. SEX <b>F</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 12, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS <b>4 28</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Mt. Airy</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4733 Ridge Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Douglas Collins Condon</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Dean Bair</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-36-8290</b>		17. INFORMANT ADDRESS <b>Vicky F. Tinkler, Same As #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2000</b> <b>DIFFUSE HISTIOCYTIC LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>2 SEP</b> , 19 <b>81</b> , to <b>10 SEP</b> , 19 <b>81</b> , that (I) ( <del>lost</del> ) saw the deceased alive on <b>7 SEP</b> , <b>81</b> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>will</del> ) view the body after death.									
22b. SIGNATURE <b>R. L. Ruxer Jr.</b>						DEGREE <b>BCRC</b>		22c. DATE SIGNED <b>10 SEP 81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. L. Ruxer Jr. MD</b>						22e. ADDRESS <b>BCRC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-14-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Taylorsville</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Taylorsville, Carroll, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr., Sykesville, Md.</b>						25. REG. DEPT. OF HEALTH AND MENTAL HYGIENE, REGISTRAR'S SIGNATURE <b>SEP 14 1981</b>			



April 12, 1904

Carroll Co.

Carroll Co. General Hospital, Housatonic

to the Housatonic Hospital

Carroll Co. General Hospital

to the Housatonic Hospital

Carroll Co. General Hospital

to the Housatonic Hospital

to

SEP 14 1981

Charles W. Butler, Jr., Housatonic, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Clara E. Geisbert</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>09 21 81</i>			2b. HOUR <i>0510 M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 01 73</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>87</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co Gen'l Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <i>MD</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13e. STREET ADDRESS <i>14 Bond Street</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry A. Reed</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth E. Cole</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>William E. Geisbert, 5730 Bells Lane Frederick, Md. 21701</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>1539 IMMEDIATE CAUSE (a) Carcinoma of the colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~ 9 mos</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____					
22a. I certify that (1) this hospital attended the deceased from <i>9/14</i> , 19 <i>81</i> , to <i>9/21</i> , 19 <i>81</i> , that (1) (we) last saw the deceased alive on <i>9/20</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did not) view the body after death.									
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) <i>Hyla S. Baker</i>					DEGREE _____		22c. DATE SIGNED <i>9-21-81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hyla S. Baker</i>					22e. ADDRESS <i>210 Washington Heights Med Ctr Westminster MD 21157</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept 23, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick, Frederick, Md.</i>			
24. FUNERAL DIRECTOR <i>Smith, Fadeley, Keeney, Basford Funeral Home</i> <i>106 East Church St., Frederick, Md. 21701</i>						25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <i>SEP 24 1981</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

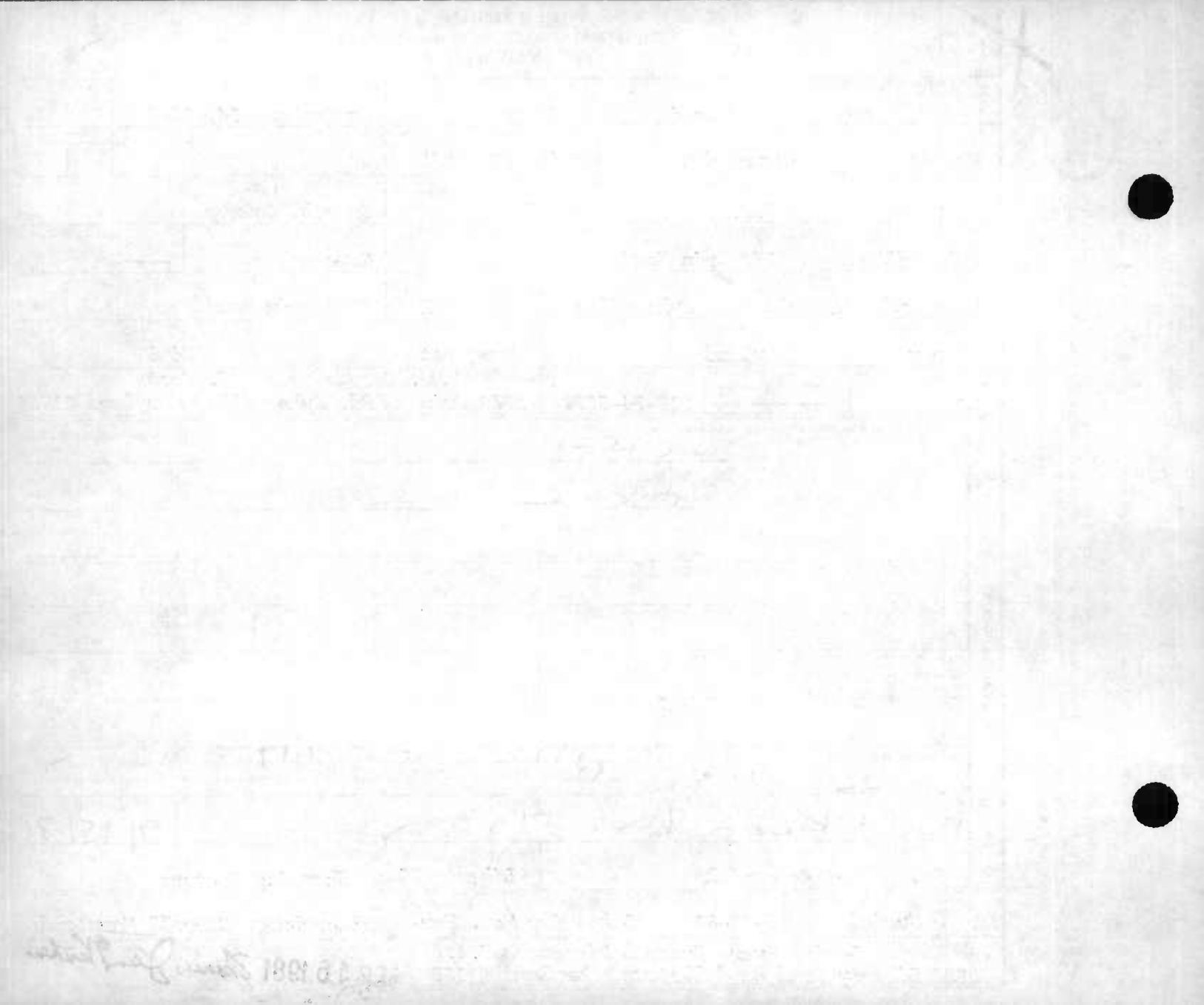
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Mary Cecelia Goetz</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>September 14, 1981</i>			2b. HOUR M <i>AM</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 27, 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Sykesville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2339 Erin Road</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Sykesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Hyland</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Hill</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-74-5794</i>		17. INFORMANT <i>Mr. George J. Goetz</i> ADDRESS <i>J. Goetz Rd. Sykesville, Maryland 21784</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CNA</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <i>ASCUR</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7/17/75</i> , 19 <i>75</i> , to <i>9/11/81</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>9/12</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <i>Robert Kroopnick</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/15/81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Robert Kroopnick</i>				22e. ADDRESS <i>Liberty Plaza Shopping Center</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-18-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eldersburg Carroll Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors P.A.</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 15 1981</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>		
26. ADDRESS <i>8728 Liberty Road Randallstown, Maryland 21133</i>								

BP





## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT F. HAGEN.			2a DATE OF DEATH MONTH DAY YEAR 9/11/81		2b HOUR M
3 SEX Male	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 11 10 07		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10 CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GEN. HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) computer anal.	12b. KIND OF BUSINESS OR INDUSTRY Martin's	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD			13c. CITY OR TOWN Pinksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST CHRISTIAN G. HAGEN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA L. FAHY Knighton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-D-4923		17 INFORMANT ADDRESS Hagen - Pinksburg, MD	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5680 DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS (c) GANGRENE OF BOWEL DUE TO ADHESIVES DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SEVERE CARDIOVASCULAR DISEASE AND DIABETES					
19a. DATE OF OPERATION 8-30-81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE SMALL BOWEL		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-29-81, 1981, to 9-11-81, 1981, that (I) (we) last saw the deceased alive on 8-10-81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE HAGEN		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-11-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HANS NIPKOW		22e. ADDRESS WESTMINSTER MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/14/81	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD	
24 FUNERAL DIRECTOR NAME PRUIS Funeral Home, Westminster		25. DATE RECEIVED BY REGISTRAR 25a. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that these death certificates be executed within 24 hours after death. Prior to death, the physician should be consulted to determine the cause of death and to complete the certificate. The law requires that the physician's signature be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. The detached certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH				2c. HOUR			
FIRST MIDDLE LAST Willis Carroll Jones		MONTH DAY YEAR 9 20 81				5:11 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Male	White	Jan. 30, 1909		72 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.			Carroll MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster	Carroll Co., Genl. Hospital			Factory Worker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Carroll		Mariottsville		NO <input type="checkbox"/>		1720 Arrington Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Thomas Lindon Jones				FIRST MIDDLE LAST Margaret Brannock Richardson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				214-07-9105		Miss Elizabeth Jones, Mariottsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>alcohol fibrillation, ASHD, recurrent ventricular arrhythmias</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>81</u> to <u>9/20</u> 19 <u>81</u> , that (I) (we) lost <u>9/19</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>Saulew Espenschied MD</u>				22c. DATE SIGNED <u>9/20/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Sept. 23, 1981		Richardson's Cem.		Church Creek, Dor. Md.			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.						25a. DATE REC'D. BY REGISTRAR SEP 23 1981			

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300
301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400
401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500
501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600
601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700
701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800
801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900
901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Abysius Kelly</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 2 1981</b>			2b. HOUR <b>11 '8 M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 22 98</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD			
10 CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Springfield Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>-</b> 13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2842 Woodbrook Ave.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank J Kelly</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary C McCartney</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-54-6894</b>		17. INFORMANT <b>Donald, Fahey</b> ADDRESS <b>2704 Bostlyn Ave 2121</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> Approximate interval between onset and death: <b>days</b> years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Scleroderma - multiple decubiti</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>57</b> , to <b>09-02</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>09-02</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Suha Ozgun, M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9-2-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Suha Ozgun, M.D.</b>					22e. ADDRESS <b>Springfield Hospital Center Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Sept. 4, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, P.A. 8728 Liberty Road Randallstown, MD. 21133</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Parthen</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



8/11/83

Kelly, James

1000 1st St. N.E.  
Albuquerque, N.M. 87102

Phone (505) 243-1111

Telex 154100

Radio 154100

NO

1000 1st St. N.E.

Albuquerque, N.M. 87102

Phone (505) 243-1111

Telex 154100

Radio 154100

NO

1000 1st St. N.E.

Albuquerque, N.M. 87102

Phone (505) 243-1111

Telex 154100

Radio 154100



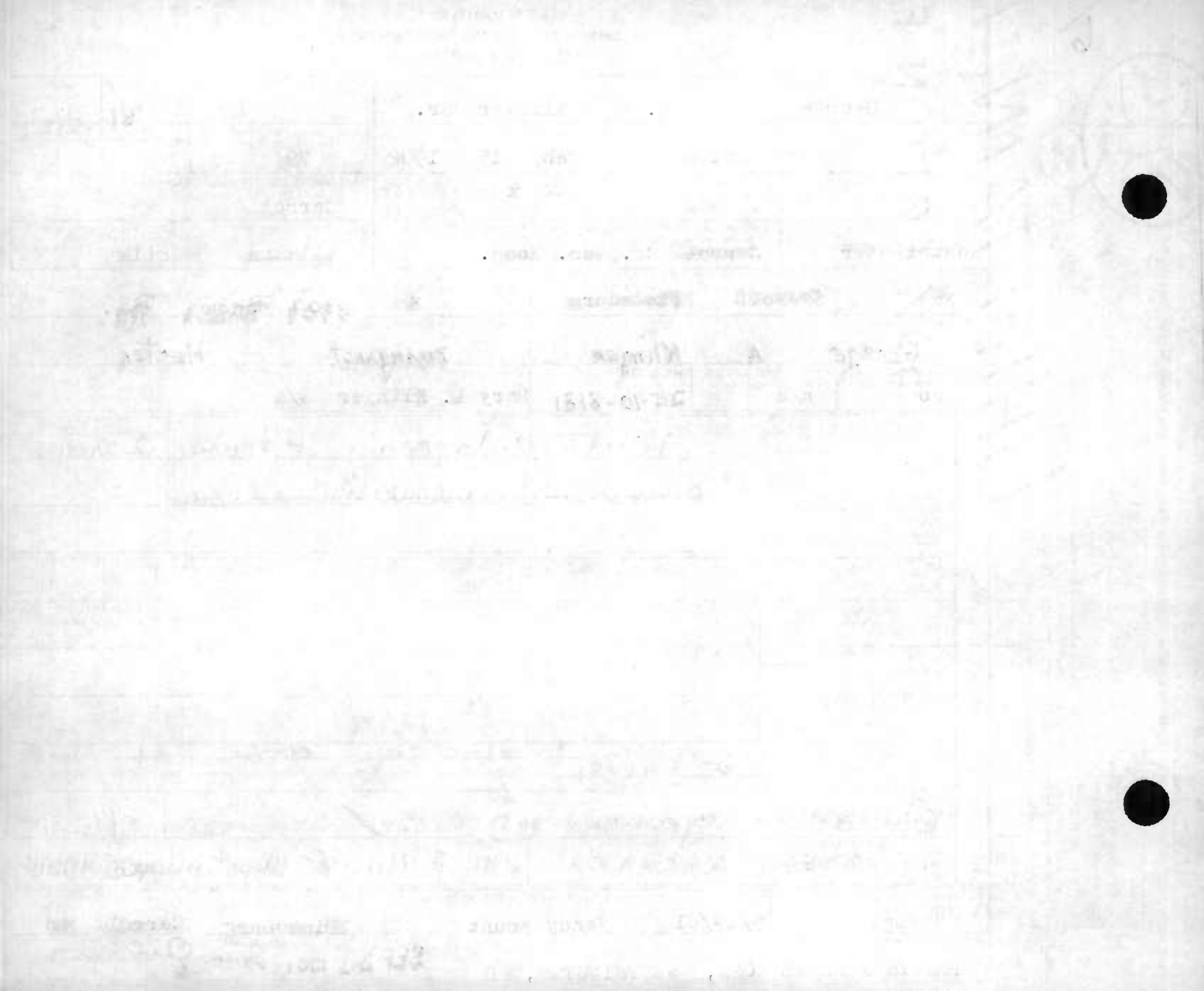
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH MONTH DAY YEAR		
			George A. Klinger Sr.		9-16-81		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.	
male		white		Feb 15 1902		79 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md		USA				Carroll MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll Co. Gen. Hosp.		milkman		milk	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN		13c. STREET ADDRESS		
Md			Carroll		1907 Brown Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
George A Klinger			Margaret Hecter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
no			n/a		Mary E. Klinger S/A		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-4-1979</u> to <u>9-6-1981</u> , that (I) (we) last saw the deceased alive on <u>6-24-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Chitrachedu Nagananna</u> DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/16/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRACHEDU NAGANNA</u>			22e. ADDRESS <u>174 E Main St. Westminster MD 21157</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>9/19/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sandy Mount</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Finksburg Carroll Md</u>	
24. FUNERAL DIRECTOR NAME <u>PRITTS FUNERAL HOME, WESTMINSTER, MD</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 21 1981</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

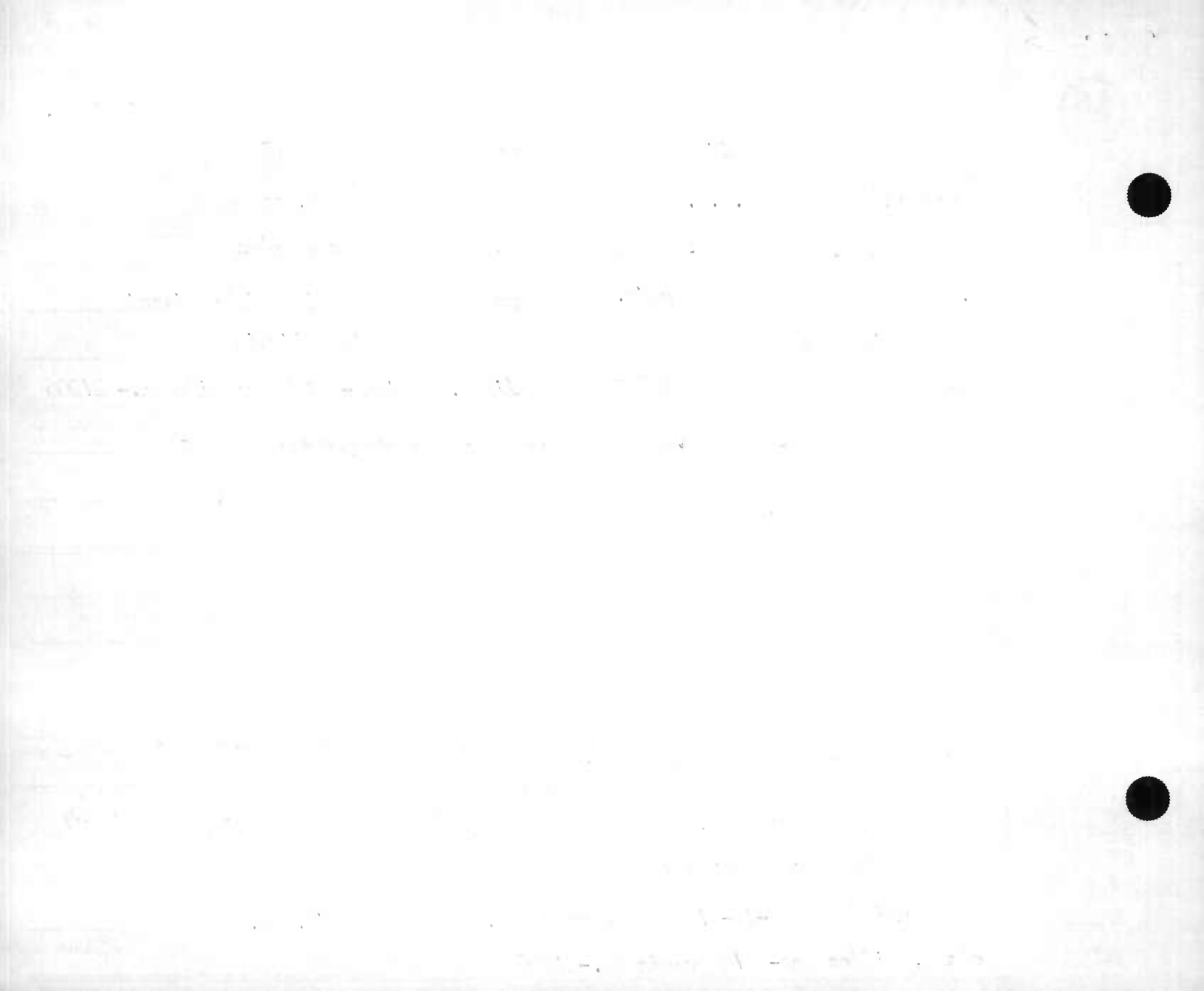
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 3 8 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ella Mae Kurtz			2a. DATE OF DEATH MONTH DAY YEAR 9 10 81		2b. HOUR 10 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 19 93		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Phelps		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Ritchie		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. MD 294878		17. INFORMANT ADDRESS Emily J. Benton - 4104 Parkside Dr. - 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis Cardiovascular d/c</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 16</u> 19 <u>81</u> , to <u>September 10</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>September 10</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jae M. Park		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-10-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAE M. PARK, MD		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-14-81		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 14 1981			
				25b. REGISTRAR'S SIGNATURE James J. Nathan			

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

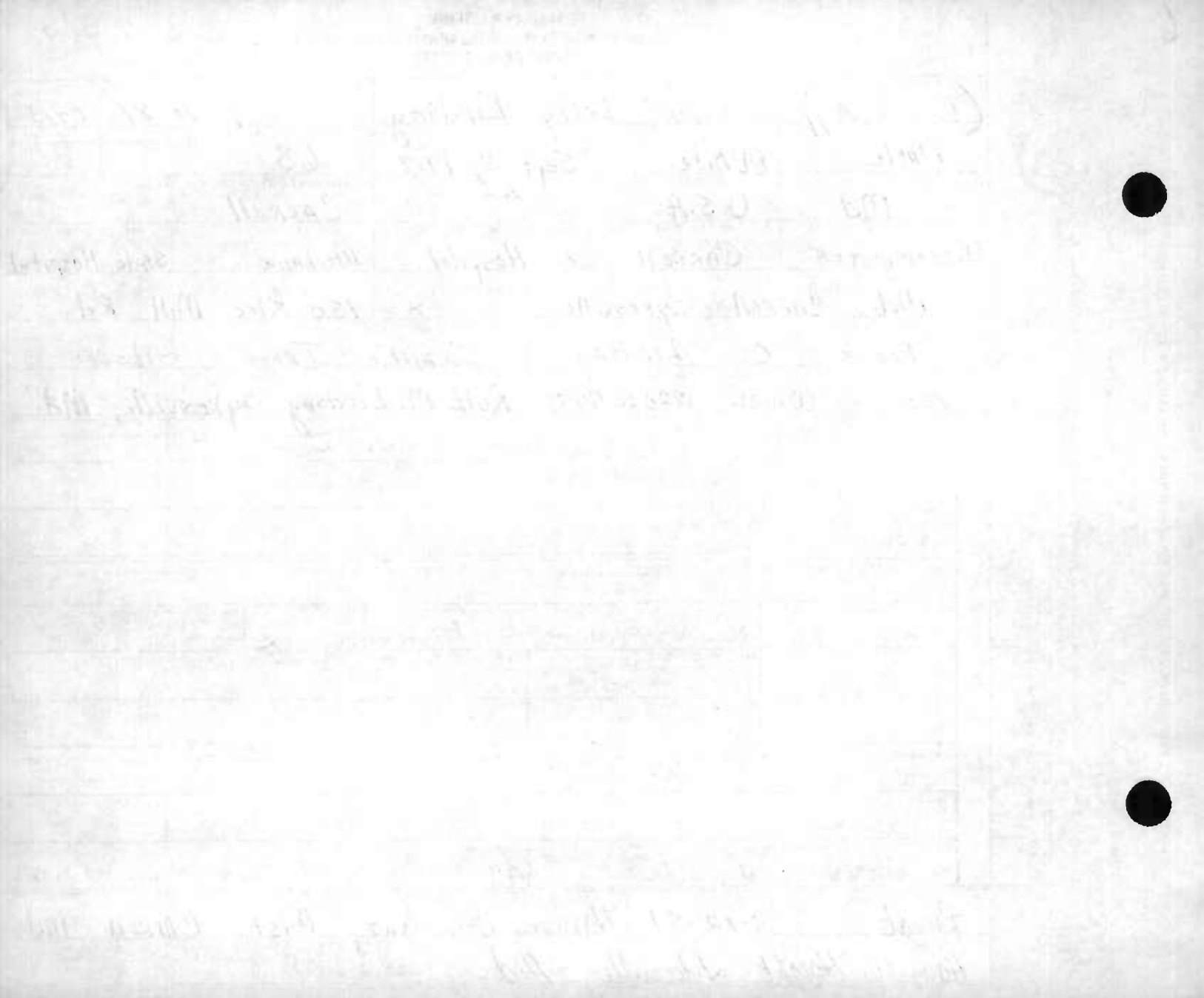
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 3 8 5 6	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>(Lindsay) FRANK LeRoy Lindsay</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-10-81</b>		2b. HOUR <b>0413M</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 3, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Hospital</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Sykesville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK O. Lindsay</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wenithic Irene Gibson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 220 03 7471</b>		17. INFORMANT ADDRESS <b>Ruth M. Lindsay Sykesville Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>Aug 1, 81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding extensive diverticulosis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 26, 19 81</b> to <b>Aug 27, 19 81</b> , that (I) (we) lost saw the deceased alive on <b>Aug 27, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>Wenifredo N. Iglesias</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WENIFREDO N. IGLESIA</b>		22e. ADDRESS <b>49 Frederick St. TANEY TOWN Md 21781</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>9-12-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Grove Cntry</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>Grist, CARROLL Md.</b>		25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <b>SEP 15 1981</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b>		ADDRESS <b>Sykesville, Md.</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the hospital, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR					8 1 2 3 8 5 7						
1. DECEASED NAME					2a. DATE OF DEATH						
[TYPE OR PRINT] FIRST MIDDLE LAST					MONTH DAY YEAR						
Howard C. Magers, Jr.					Sept. 23, 1981						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7b. HOUR			
Male		White		Jan. 20, 1922		59 YRS.		19:17 <sup>P</sup>			
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll Co., MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. General Hospital				Carpenter					
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland					Carroll		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Howard C. Magers, Sr.					Evelyn Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes					WW 2		219-01-1706 G. Nadine Magers, Same As #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I: DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>											
4100 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>MYOCARDIAL ISCHEMIA</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>PREVIOUS MYOCARDIAL INFARCTION</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>  </u> , to <u>Sept 23</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>Sept 22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
<u>Gilcin F. Magadors, Jr., M.D.</u>										Sept. 25, 1981	
22d. PHYSICIAN'S NAME [TYPE OR PRINT]								22e. ADDRESS			
GILCIN F. MAGADORS, JR., M.D.								810 Pal House Ave. Frederick, Md. 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial				9-26-1981		Pine Grove			Mt. Airy, Carroll, Md.		
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles W. Burrier, Jr., Sykesville, Md.								SEP 28 1981		<u>James J. Harrison</u>	

BP





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 3 8 5 8

1- FOR  
STATE  
REGISTRAR

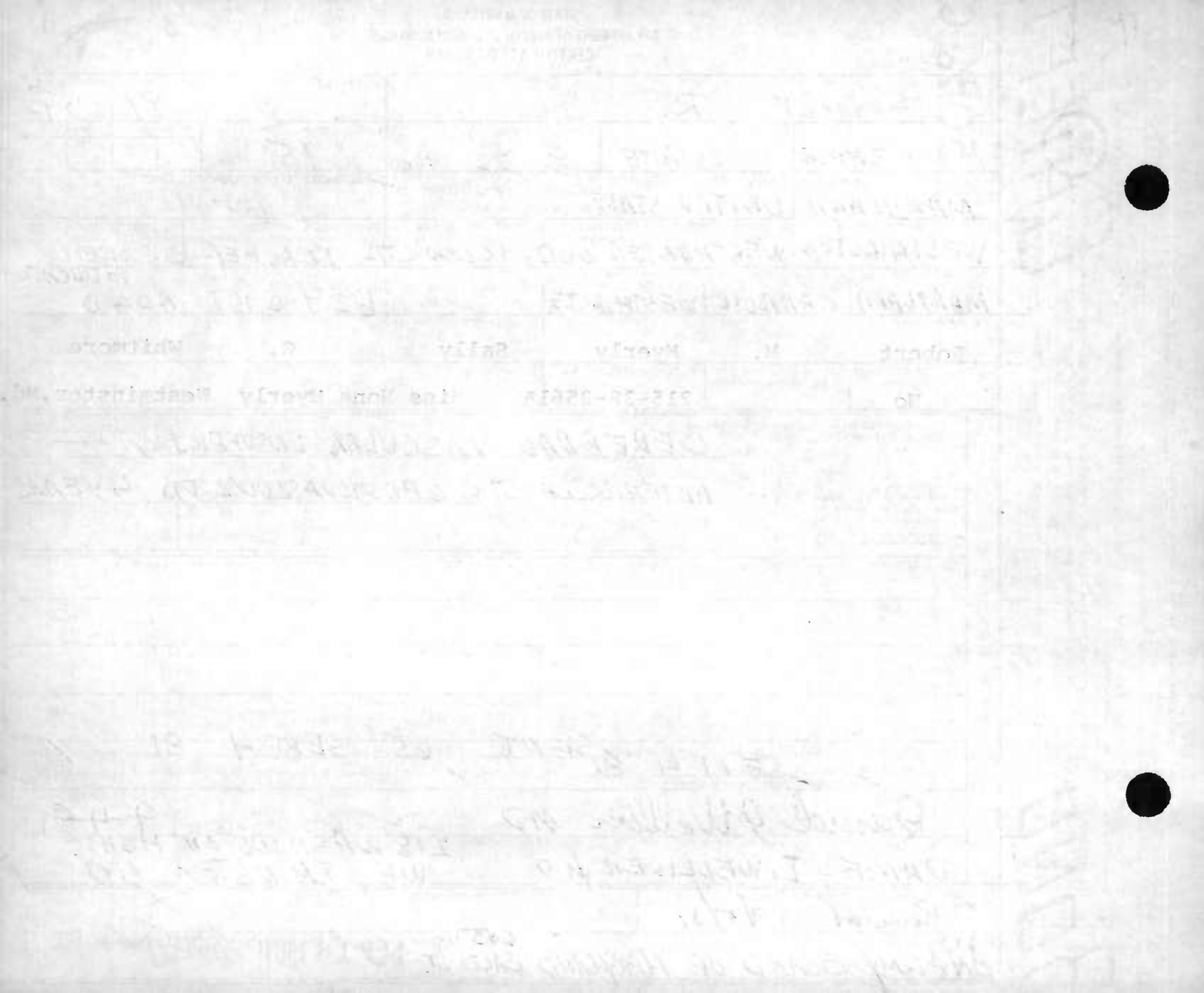
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret R. Myerly</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>4</b> YEAR <b>81</b>			2b. HOUR <b>05</b> MIN. <b>10 PM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>22</b> YEAR <b>1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.				
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTMINSTER NURS &amp; CONV. CTR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>629 GIST ROAD</b>	
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>M.</b> LAST <b>Myerly</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Sally</b> MIDDLE <b>G.</b> LAST <b>Whitmore</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-38-2561A</b>		17. INFORMANT ADDRESS <b>Miss Nona Myerly Westminster, Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR INSUFFICIENCY</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DIS</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 YEARS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>9/5/81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 4</b> , 19 <b>81</b> , to <b>SEPT 4</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>SEPT 4</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Daniel J Welliver M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9-4-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL J. WELLIVER M.D.</b>				22e. ADDRESS <b>218 WASHINGTON HEIGHTS WESTMINSTER MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9/5/81</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>ANATOMY BOARD OF MARYLAND</b> ADDRESS <b>BALTO ST.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1901

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

1901

PRINTED BY THE

UNIVERSITY OF THE STATE OF NEW YORK

NEW YORK  
1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 3 8 6 0	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST
CORA			M.		MYERS
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		CAUC.		MONTH DAY YEAR 4 1 1891	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
BALTIMORE MD		USA		90 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
WESTMINSTER		CARROLL LUTHERAN VILLAGE		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Homemaker			Home		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Md.			Carroll	Finksburg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST JOHN TINKLER			FIRST MIDDLE LAST VIRGINIA KROUT TINKLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN		None		189-07-1448 Carroll K. Tinkler Finksburg, Md	
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis - primary site</u> 1890 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>probably right kidney</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 10</u> , 19 <u>64</u> , to <u>September 24</u> , 19 <u>64</u> , that (1) (we) lost saw the deceased alive on <u>Sept 4</u> , 19 <u>64</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.		22b. SIGNATURE <u>O. E. McWilliams</u> M.D.		22c. DATE SIGNED <u>Oct 5 1964</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
O. E. McWilliams		11904 Reisterstown Rd Reisterstown Md 21138			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		9-28-81	Bethel Cemetery		Finksburg Carroll County Md
24. FUNERAL DIRECTOR Pritts Funeral Home Westminister, Md.					
25. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					



*[The page contains several paragraphs of extremely faint, illegible text, likely bleed-through from the reverse side. The text is arranged in horizontal lines across the page.]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, when any injury, or other traumatic event, the medical examiner must be notified at once.

HP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Geraldine S. Myers		2a. DATE OF DEATH MONTH DAY YEAR 9 4 81		2b. HOUR 0431 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 20 1921		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Carroll Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Carroll		13c. CITY OR TOWN Westminster	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Stocksdale				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Coppersmith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Dennis Myers Westminster, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE BRAIN STEM STROKE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/3</u> , 19 <u>81</u> , to <u>9/4</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert Kyd Prith Sr.</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/4/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-7-81		23c. NAME OF CEMETERY OR CREMATORY Sandy Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Robert Kyd Prith Sr. Westminster, Md</u>							

SEP 5 1981

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Item 13 for  
Nursing Code. 9/18  
R.T.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frances Perry</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9.13.81</b>		2b. HOUR 12 N M	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08.09.92</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>UNKNOWN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARDOLL</b> MD.					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTMINSTER NURS. &amp; CONV. CTR</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNKNOWN</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		13a. STATE <b>MD</b>			
13b. COUNTY <b>UNKNOWN</b>		13c. CITY OR TOWN <b>UNKNOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT ADDRESS <b>WESTMINSTER, MD. CATHERINE NEWMAN 325 SPRINGDALE ROAD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIO-CEREBRAL VAS. DIS</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>9/24 1976</b> , to <b>9-13 81</b> , that (b) (we) last saw the deceased alive on <b>SEPT 13 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Daniel J Welliver MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-13-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL I. WELLIVER MD</b>		22e. ADDRESS <b>218 WASHINGTON HEIGHTS MEDICAL WESTMINSTER MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>09-15-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>			
25a. DATE REC'D. BY REGISTRAR <b>SEP 16 1981</b>		25b. REGISTRAR <b>James J. [Signature]</b>			

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Pottorff, E.  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn M. J. Pottorff		2a. DATE OF DEATH MONTH DAY YEAR 9 11 81 2b. HOUR 5:32 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 25 1909	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7a. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hwf
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pa. 13b. COUNTY York 13c. CITY OR TOWN Hanover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Howell R. Leppo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl E. Cooper	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-24-7144A	
17. INFORMANT ADDRESS Mr. Milton E. Pottorff, Hanover, Pa.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CIRCULATORY FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CONDITIONS, IF ANY, WHICH gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) MIXED CONNECTIVE TISSUE DISEASE			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/27 1981, to 9/11 1981, that (I) (we) lost saw the deceased alive on 9/11 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Francis J. Pottorff MD		22c. DATE SIGNED 9/11/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-14-81	
23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home Hampstead, Md. 21074		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 18 1981 Francis J. Pottorff	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP  
DHMH - 16 50M / 81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SEP 1 1981



## CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Last</u> <u>First</u> <u>Middle</u> <u>Rhinecker</u> <u>Florence</u> <u>J.</u>			2a. DATE OF DEATH MONTH <u>9</u> DAY <u>10</u> YEAR <u>81</u>		2b. HOUR <u>920</u> <u>AM</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>9</u> DAY <u>5</u> YEAR <u>86</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>95</u> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u> MD		
10. CITY OR TOWN OF DEATH <u>Mt. Airy</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Pleasant View Nsg. Home</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Home maker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md</u>	13b. COUNTY <u>CARROLL</u>	13c. CITY OR TOWN <u>Westminster</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>149 S. Springdale Rd</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>TUCKER</u> LAST <u>TUCKER</u>		15. MOTHER'S MAIDEN NAME FIRST <u>HELEN</u> MIDDLE <u>BERDETTE</u> LAST <u>BERDETTE</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>NONE</u>	17. INFORMANT ADDRESS <u>Bonnie Warehime Westminster, Md</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>5850</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis gran negative from V.T.I</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC renal failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>10 deep</u> <u>4 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>General Sem. Hx, CVA, ASCVD, COPD.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28/81</u> 19 <u>81</u> to <u>9/10</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>9/3/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Melvin J. Kordon</u> MD				22c. DATE SIGNED <u>9/10/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Melvin J. Kordon</u>				22e. ADDRESS <u>2000 Ceccony Plaza Columbia Md 21044</u>	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>9-12-81</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Lutheran</u>		23d. LOCATION CITY OR TOWN <u>Uniontown</u> COUNTY <u>Carroll</u> STATE <u>Md</u>
24. FUNERAL DIRECTOR <u>Robert Kyle Prutts Jr. Westminster, Md.</u>				25. DATE REC'D. BY REGISTRAR <u>SEP 16 1981</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Willard Gray Rush</u>			2a. DATE OF DEATH MONTH <u>09</u> DAY <u>11</u> YEAR <u>81</u>			2b. HOUR <u>1445</u> M	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>01</u> DAY <u>13</u> YEAR <u>99</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Lynchburg, Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u> MD.	
10. CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Auditor</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Co.</u>							
13a. STATE <u>Maryland</u>				13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Westminster</u>	
14. FATHER'S NAME FIRST <u>James</u> MIDDLE <u>H.</u> LAST <u>Rush</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Ottawa</u> MIDDLE <u>M.</u> LAST <u>Johnson</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WWD Army</u>		17. INFORMANT <u>Grace Cooper Rush</u>		ADDRESS <u>Westminster, Md. 21157</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Renal failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <u>8-26</u> , 19 <u>81</u> , to <u>9-11</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>9-11</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death.							
22b. SIGNATURE <u>Alva S. Baker</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9-11-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alva S. Baker</u>				22e. ADDRESS <u>28 Washington Heights Med Ctr</u> <u>Westminster MD 21157</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9-14-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore</u> <u>Baltimore</u> <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Thomas D. Fletcher &amp; Son F.H.</u> ADDRESS <u>54 East Main St.</u> <u>Westminster, Md. 21157</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 15 1981</u>			
25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

No.		Name		Origin		Date		Remarks	
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9
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11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12
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99	99	99	99	99	99	99	99	99	99
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100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Marie Frieda Seidler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 24 81</b>		2b. HOUR <b>1035</b> M
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 93</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cattoll County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Cattoll County General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Winksburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Witz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Kirschbaum</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-74-6787</b>		17. INFORMANT <b>Westminster, Md. 21157</b> <b>Alma M. Hofmann 409 Farm Creek Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b> <b>about 10 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>					
19a. DATE OF OPERATION <b>9-24</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>7-24</b> , 19 <b>81</b> , to <b>9-24</b> , 19 <b>81</b> , that (1) (we) lost saw the deceased alive on <b>9-18</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Alma M. Hofmann</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-24-81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alma S. Baker</b>			22e. ADDRESS <b>218 Washington Hts Med Ctr</b> <b>Westminster MD 21157</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-25-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son F.H.</b>		25. ADDRESS <b>254 East Main Street</b> <b>Westminster, Md. 21157</b>		26. DATE OF REGISTRATION <b>SEP 24 1981</b>	

BP

No

213-74-6787

Alma M. Hofmann 109 Farm Creek Rd.

Westminster, Md. 21157

Kirschbaum

Anna

222 Baltimore Blvd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL E. SMITH					2a. DATE OF DEATH MONTH DAY YEAR 9 25 81					2b. HOUR 1216P M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 16 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus service		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3294 York Street		
14. FATHER'S NAME FIRST MIDDLE LAST George Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Barber						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-01-5038		17. INFORMANT Mrs. Mae Smith, Manchester, Md.		ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension, diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>81</u> , to <u>9/25</u> , 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>9/25</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 9/25/81
22b. SIGNATURE <u>[Signature]</u>				22d. ADDRESS ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-28-81		23c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.				
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 30 1981 <u>[Signature]</u>						





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23868	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Richard John Burnell</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 21 1981</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 25 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>53</b>		7. IF UNDER 1 YR. MONTHS DAYS		7b. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 21 1981</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.	
10. CITY OR TOWN OF DEATH <b>Union Bridge</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>104 Elgar St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>waiter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Union Bridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>104 Elgar St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert D. Stephan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Belle Martin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>n/a</b>		17. INFORMANT ADDRESS <b>George Stephan, Westminster, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Richard J. Jones</b>				TITLE (SPECIFY) <b>Deputy</b> M.D.				MEDICAL EXAMINER		DATE SIGNED <b>21 Sept 81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Richard J. Jones</b>				ADDRESS <b>COC Hosp. Westminster Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9/24/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kriders Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll Md.</b>			
24. FUNERAL DIRECTOR NAME <b>PRITTS FUNERAL HOME, WESTMINSTER, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Thelma Sue Treadwell		Sept. 25, 1981		17:31 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	White	MONTH DAY YEAR Dec. 22, 1911		69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
W. Va.	USA			CARROLL Carroll MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Westminster	CARROLL CO. GEN. HOSP		Homemaker		Own Home
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Carroll	Westminster	13e. STREET ADDRESS 148 West Main Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
FIRST MIDDLE LAST Edward H. Skaggs		FIRST MIDDLE LAST Ruth Louise Wickline		Westminister, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		217 09 1698 Mr. Lewis J. Treadwell	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREbroVASCULAR ACCIDENT 4310 DUE TO, OR AS A CONSEQUENCE OF (b) SYSTEMIC HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Systemic lupus erythematosus, Renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/24/81, 19 81, to 9-25-19 81, that (I) (we) lost saw the deceased alive on 9/25/19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
CHITRAKETHU NAGANNA		MD		9/25/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
CHITRAKETHU NAGANNA		174 E Main St Westminster MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Sept. 28, 1981		Queens Point Cem.	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Keyser		Mineral		W. Va.	
24. FUNERAL HOME (NAME)		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Markwood Funeral Home		11 S. Mineral St. Keyser W. Va.		SEP 29 1981	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 27 hours after death report with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 3 8 7 0			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mildred A. Welsh				2a. DATE OF DEATH MONTH DAY YEAR September 8, 81		2b. HOUR 1:20a.m.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 21, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10 CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6317 Oakland Mills Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deli Worker-Sanitary Food Store	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Nickoles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Shipley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17 INFORMANT Mr. William A. Welsh 21784 6317 Oakland Mills Road Sykesville, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Cardiac Respiratory Arrest DU TO, OR AS A CONSEQUENCE OF 1. Ca of Cold & Extensive Secondary DU TO, OR AS A CONSEQUENCE OF H.A.S.C.V.D. (b) (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 (OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.							
22b. SIGNATURE 				DEGREE MD		22c. DATE SIGNED 9-8-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. BABU Y. Rao				22e. ADDRESS 8811 Liberty Rd, Randallstown MD 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/11/81		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A. 8728 Liberty Road Randallstown, MD, 21133				25a. DATE REC'D. BY REGISTRAR SEP 10 1981			
				25b. REGISTRAR'S SIGNATURE James J. Nathan			

BP

Can be in direct front  
of (1) to 2  
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Cell 100, 101, 102  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1 - FOR STATE REGISTRAR					CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ernest C. Wisner</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 3, 1981</b>		
3 SEX <b>male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 27, 1912</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Finksburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3806 Tupelo Road</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baptist Home of Maryland</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Finksburg</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James W. Wisner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther B. Bixler</b>		13d. STREET ADDRESS <b>3806 Tupelo Road</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-01-7763</b>		17. INFORMANT ADDRESS <b>Miss Thelma Wisner, Finksburg, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma right upper lobe with bony metastasis to ribs, spine and extremities</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 23</b> , 19 <b>81</b> , to <b>September 3</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>September 1</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.						
22b. SIGNATURE <i>Richard Y. Dalrymple</i> DEGREE				22c. DATE SIGNED <b>09-03-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Y. Dalrymple, M.D.</b>				22e. ADDRESS <b>Carroll Plaza, Westminster, Md. 21157</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-5-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Balto Md.</b>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Eline Funeral Home Hampstead, Md. 21071</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 9 1981</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1 - FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>Bulah O Zepp</u>						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX <u>Female</u>						4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>07 23 1896</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>						7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll Co</u> MD.	
10. CITY OR TOWN OF DEATH <u>Westminster</u>						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County Gen'l Hospital</u>					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Hwf</u>						12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <u>MD.</u>						13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Manchester</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George E. Warner</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Manilla Strevig</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>						16b. SOCIAL SECURITY NO. <u>216-05-0423</u>		17. INFORMANT ADDRESS <u>Mrs. Dorothy Alban, Manchester, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> 1531 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction of Transverse Coronary Artery</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>month</u> <u>month</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Outt milt ASCVD, heart failure</u>											
19a. DATE OF OPERATION <u>8/27/81</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of Transverse Coronary Artery</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>8/10/81</u> , 19 <u>81</u> , to <u>9/11</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>9/4/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Pat A. Zell</u> , M.D.						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/12/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>9-14-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lineboro Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Lineboro Carroll Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Eline Funeral Home, Hampstead, Md.</u>						ADDRESS <u>21074</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 18 1981</u>		25b. REGISTRAR'S SIGNATURE <u>Frances Jean Nathan</u>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

SEP 11 1981

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SEP 18 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 8 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Milton Richard Zollickoffer			2a. DATE OF DEATH MONTH DAY YEAR 9 10 81			2b. HOUR A 3:48 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 20 30		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1035 Oak Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cable splicer		12b. KIND OF BUSINESS OR INDUSTRY electric	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elwood Zollickoffer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Devilbiss		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 1954-56		17. INFORMANT Dorothy Zollickoffer		18. ADDRESS 1035 Oak Drive Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE COLON 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JULY 11, 1981, to AUG 26, 1981, that (I) (we) last saw the deceased alive on SEPT 3, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Arthur L. Rudo MD		DEGREE M.D.		22c. DATE SIGNED 9/10/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDO, MD	
22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER MD 21157		22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/13/81		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Uniontown Carroll Md.	
24. FUNERAL DIRECTOR NAME D. D. Zollicker		ADDRESS New Windsor, Md.		25a. DATE REC'D. BY REGISTRAR SEP 14 1981		25b. REGISTRAR'S SIGNATURE James J. Martin	

RECEIVED  
JAN 10 1964

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

MEMORANDUM

TO :

FROM :

SUBJECT :

RE :

DATE :

BY :

FOR THE RECORD :

ADMINISTRATIVE :

TECHNICAL :

FINANCIAL :

LEGAL :

OTHER :

REMARKS :

APPROVED :

SPECIAL AGENT IN CHARGE

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

289 (A) 938